TESTIMONY

HB 153
and
HEALTH CARE IN OHIO

HOUSE FINANCE COMMITTEE
SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

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OHIO CONSUMERS FOR HEALTH COVERAGE

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Good morning, Chairman Burke, Ranking Member Goyal, and Representatives Sears, Adams and Weddington. My name is Col Owens. I am a Senior Attorney at the Legal Aid Society of Southwest Ohio, LLC, and serve as co-chair of Ohio Consumers for Health Coverage (OCHC), a statewide consumers’ health care advocacy coalition working for quality affordable health care for all. OCHC has worked hard to bring together a broad representation of consumer interests to achieve one united voice regarding health care reform. With me are my colleagues Holly Pendell and Cathy Levine.

This morning I will begin by identifying several major themes in the health care/Medicaid sections of HB 153 that we support as essential to meaningful health care reform in Ohio. I will then begin to address problem areas that require attention, which will be followed up on by my colleagues.

First, however, the significance of this area of the budget cannot be exaggerated. Ohio’s Medicaid program serves well over 2 million people, and that number has grown significantly during the recession. The recession also has contributed greatly to Ohio’s uninsured problem. The 2010 Ohio Family Health Survey found roughly 1.4 million uninsured adults, an increase of 150,000 since the 2008 survey. Until full implementation of the Affordable Care Act (federal health care reform) in 2014, these people will place a substantially increased burden on Ohio’s already stressed health care system.

In testimony before both the House Finance Committee and this Subcommittee, Greg Moody, Director of the Office of Health Transformation (OHT), set out several major themes for Medicaid transformation and health care reform in Ohio. The central goal is a health care system that delivers better care, with higher quality outcomes, at lower cost. We fully support this goal. A key strategy for achieving this goal is greater care coordination throughout the entire system, including but not limited to Medicaid, especially for those with chronic health conditions. OHT’s focus is based in large part on “hotspots,” or areas where high cost is concentrated. For example, 4% of Medicaid participants account for 50% of Medicaid spending. It should be noted that this disproportionate spending takes place in the unhappy context of Ohio spending more overall for health care than most other states, while ranking 42nd among states in a battery of health outcomes. In addition to focusing on better care for high-cost patients, we need to focus on moving care from high cost to lower cost settings.

The need for patient-centered medical homes for all enrollees, with more focused “health homes” to provide more intensive coordinated care to those with chronic illness; for payment reform that reimburses generally for quality over volume; and for effective health benefit exchanges and the electronic information exchange, are all central components to OHT’s vision – and to the infrastructure to implement it being built in this budget. I should add, as an aside, that these are all key components of the Affordable Care Act - and for the very same reasons. Almost all stakeholders identify these objectives and strategies as key to achieving a higher quality, lower cost health care delivery system.

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We agree with OHT regarding the centrality of these objectives for a better system, and strongly support their inclusion in HB 153.

Another component in OHT’s blueprint is greater integration of behavioral health and physical health services. We also strongly support this goal, which has also been identified by stakeholders as a major step forward in establishing a health care system that treats the whole person. By “elevating” funding for mental health into the major Medicaid line item, Line 525, the budget helps drive more unification of services at the local level through unified funding. Services may be either co-located or coordinated through local networks. This change alleviates local communities having to provide the Medicaid match, which in many instances has cut deeply into their ability to deliver services to the non-Medicaid eligible population, and/or to provide Medicaid enrollees with non-covered services. It also makes the delivery of mutually supportive services more coordinated and efficient, and thus more effective and less costly.

Despite the focus on increased integration of behavioral and physical health services, with merged Medicaid funding, there is a disconnect between the policy goals and the amounts of money appropriated to carry them out. For example, almost $250 million is being taken out of the behavioral health system that many describe as already being in tatters. Service utilization caps and tiered provider rates for outpatient populations will negatively impact on individuals with severe mental illness, making it more difficult for them to remain in the community and out of hospitals (and prisons). One feature that could be added is a “prior authorization” process, to insure that those whose needs exceed cap levels could obtain higher levels of service where need is demonstrated.

Other major concerns among stakeholders are the inadequate amount of money available at the local level for services for non-Medicaid eligible persons; decreased funding for medications; and decreased funding for the Residential State Supplement, which provides housing assistance. All of these areas require greater scrutiny.

Finally, I want to offer a brief comment about the so-called “optional services” in Medicaid, such as dental, vision, prescription drugs, podiatry, durable medical equipment, oxygen, etc. For people who need these services, they are not optional. By including them in the budget, the Administration shows clear understanding of their importance, and the “penny wise – pound foolish” aspect of not providing them. People who go without these services often wind up in far worse conditions, if not in life-threatening circumstances, seeking help in more expensive settings. For example, a diabetic who does not receive podiatric services may well wind up having an amputation that could have been avoided.

We applaud these services being funded in the budget, and strongly urge resistance to any temptation to turn to them for funds if other areas of need are identified as requiring further funding.

Thank you for your attention to these comments. I will now turn this over to my colleague __________.